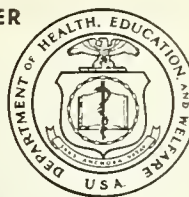


Morbidity and Mortality



Vol. 16, No. 40

WEEKLY
REPORT

Week Ending
October 7, 1967

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

BUREAU OF DISEASE PREVENTION AND ENVIRONMENTAL CONTROL

CURRENT TRENDS MEASLES

A total of 223 cases of measles was reported for the 40th week (ending Oct. 7, 1967), an increase of 47 cases over the previous week's total. The 4-week total (Sept. 10-Oct. 7) of 828 cases is approximately 48 percent of the cases reported for the same period last year.

The reporting for the 40th week concludes the measles Epidemiologic Year 1966-67 (EY '66-'67), and marks the end of the summer plateau in measles before the yearly increase coincident with the opening of school throughout the nation. In Figure 1, the reported cases of measles (accumulated by 4-week periods) for EY '66-'67 are compared to the cases notified in EY '65-'66 and EY '64-'65.

For EY '66-'67, 70,638 cases of measles have been reported to the NCDC, representing one-third of the 213,992

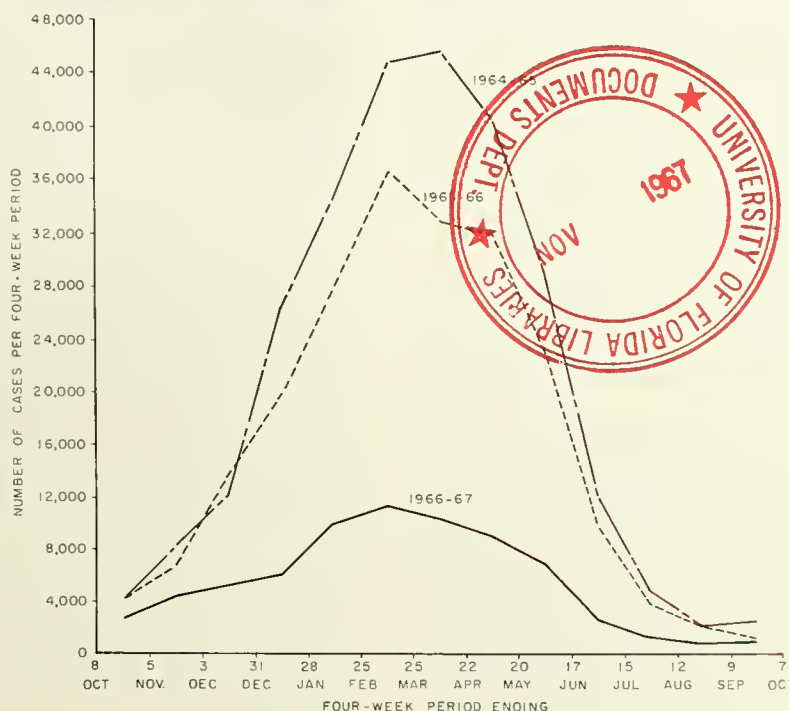
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cases reported in EY '65-'66. The recent epidemiologic year total is the lowest one on record.

In spite of these impressive figures and trends, measles has been a problem in a number of states during the past 13 weeks, particularly in the three Pacific Coastal States and in Texas, Wisconsin, and Illinois. These six states have accounted for over half of the measles reported to the NCDC during this period.

Figure 1
REPORTED MEASLES BY FOUR-WEEK PERIODS - UNITED STATES
EPIDEMIOLOGIC YEAR, 1966-67 COMPARED WITH 1964-65 AND 1965-66



CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES
(Cumulative totals include revised and delayed reports through previous weeks)

DISEASE	40th WEEK ENDED		MEDIAN 1962 - 1966	CUMULATIVE, FIRST 40 WEEKS		
	OCTOBER 7, 1967	OCTOBER 8, 1966		1967	1966	MEDIAN 1962 - 1966
Aseptic meningitis	85	92	78	2,197	2,323	1,591
Brucellosis	3	3	8	199	199	286
Diphtheria	14	3	7	115	147	192
Encephalitis, primary:						
Arthropod-borne & unspecified	32	65	---	1,242	1,687	---
Encephalitis, post-infectious	4	11	---	663	616	---
Hepatitis, serum	45	30	735	1,668	1,069	29,761
Hepatitis, infectious	823	593		29,525	24,469	
Malaria	41	16	4	1,529	324	75
Measles (rubeola)	223	472	805	58,445	190,817	360,887
Meningococcal infections, total	27	34	37	1,772	2,818	2,149
Civilian	26	33	---	1,656	2,539	---
Military	1	1	---	116	279	---
Polio myelitis, total	—	1	3	25	73	87
Paralytic	—	1	2	21	68	71
Rubella (German measles)	193	233	---	40,406	42,374	---
Streptococcal sore throat & scarlet fever ..	5,978	6,058	5,565	345,813	326,761	304,519
Tetanus	4	10	6	174	147	206
Tularemia	2	5	5	140	141	222
Typhoid fever	8	15	15	324	299	333
Typhus, tick-borne (Rky. Mt. spotted fever) ..	3	7	3	281	222	207
Rabies in animals	59	50	58	3,402	3,233	3,233

NOTIFIABLE DISEASES OF LOW FREQUENCY

	Cum.		Cum.
Anthrax:	2	Rabies in man:	2
Botulism:	2	Rubella, Congenital Syndrome:	4
Leptospirosis: Ala.-1, Ark.-2, Hawaii-1	32	Trichinosis:	49
Plague:	2	Typhus, murine: Tex.-1, Puerto Rico-1	34
Psittacosis: Tex.-1	36	Polio, Unsp.	4

EPIDEMIOLOGICAL NOTES AND REPORTS

PENTACHLOROPHENOL POISONING IN NEWBORN INFANTS - St. Louis, Missouri

From April to August 1967, nine cases of a clinically distinct illness characterized by fever and profuse sweating occurred in a small nursery for newborns in St. Louis, Missouri. Two of the cases were fatal. Early in the course of the outbreak the disease was felt to be an intoxication, but the nature of the poison and the mode of exposure of the patients remained obscure. Only after the ninth case developed was it discovered that an antimildew agent, containing a high concentration of sodium pentachlorophenate (the sodium salt of pentachlorophenol), was being used in the hospital laundry. All of the clinical, epidemiological, and biochemical evidence indicated that this outbreak resulted from pentachlorophenol poisoning. The only identified mode of exposure was skin absorption of sodium pentachlorophenate residues on diapers and other fabrics, resulting from the misuse of the antimildew agent in the final laundry rinse.

The outstanding clinical feature of the illness was extreme diaphoresis. Attendants consistently noticed that the infants' clothing and brows were drenched with sweat. Nevertheless, the neonates nursed avidly. As the disease progressed, fever rose as high as 103°F, respiratory rates increased, and breathing became labored, though auscultation of the lungs was normal and cyanosis was absent. Other common findings included tachycardia, hepatomegaly, and irritability followed by lethargy. Anorexia, vomiting, and diarrhea were notably absent. Stiffness of the neck, muscular fasciculations, and convulsions were

not observed. Skin rashes or evidences of inflammation or irritation of the skin were not seen.

Laboratory tests frequently showed a progressive metabolic acidosis, proteinuria, a rising blood urea nitrogen, and "pneumonia" or "bronchiolitis" on X-ray. Bacterial and viral cultures of blood, cerebrospinal fluid, nose, throat and stool revealed no pathogens. Autopsy findings of the two fatal cases showed fatty metamorphosis of the liver in both cases and fatty vacuolar changes in the renal tubules of one case.

All except one of the seriously ill infants, a fatal case, were transferred to other hospitals for treatment. After the first fatal case occurred, the attending physicians suspected a toxic cause and therefore promptly performed exchange transfusions on each of the seriously ill infants who were subsequently transferred for medical care. This treatment yielded dramatic results. Within minutes to hours, the infants became more responsive and had less respiratory distress. Fever and sweating disappeared, as did metabolic acidosis. Renal function returned to normal during the next few days. Except for the two fatal cases, recovery was apparently complete.

The first four cases developed between April 17 and 19 among a group of 25 infants who were in the nursery during this interval. The first infant to become ill died. The institution was closed on April 24 and thoroughly cleaned and disinfected before re-opening on May 3. A second cluster of four cases occurred between May 10

and 15. One of these also was fatal. The average age of these eight cases, at onset of illness, was 8.9 days. Several additional suspect cases with fever and sweating were detected among 13 infants who had been discharged from the hospital in apparent health between April 17 and May 15.

From the time of the first recognition of the outbreak, an intensive and persistent search was made for toxic substances in the environment of the infants. A solid-stick evaporating deodorizer had been used without change in practice for 4 years. A commercial exterminator had sprayed regularly with a carbamate insecticide monthly for 2 years within the hospital, but never in the nursery. The management of drugs and the preparation of babies' formulas revealed no deviations that were likely to permit the introduction of a toxic substance to this many babies.

For the preceding 10 months, a commercially available disinfectant containing a mixture of synthetic phenolic derivatives had been used extensively and frequently in the nursery, and had been repeatedly applied to surfaces that came in contact with infants' skin.

One-dimensional thin-layer chromatography of serum specimens obtained from the first eight cases was performed. These tests revealed the presence of a phenolic substance in all test specimens, which was similar to a phenolic ingredient of the disinfectant. This substance was thought to be the toxic chemical causing the disease.

The nursery was closed and recleaned. Use of the suspect disinfectant was abandoned, and all equipment that had been treated with it was discarded or rendered free of phenolic residues by extensive cleaning with alcohol. New linens and diapers were purchased and the nursery reopened July 11.

On August 29, an 8-day-old infant had the acute onset of an illness identical to the previous eight infants. The infant received an exchange transfusion and promptly recovered. A follow-up survey of infants discharged from the hospital in July and August revealed six additional infants who had the characteristic excessive sweating in a milder form of the same syndrome.

The formerly suspect disinfectant was no longer in use. Reinvestigation of laundry procedures disclosed a previously overlooked source of phenols. An antimildew agent, containing 22.9 percent sodium pentachlorophenate and 4.0 percent trichlorocarbanilide, was being used in the terminal rinse of all nursery linens and diapers, despite a warning on the label that the compound "must not be used" in laundering diapers.

This product had been in use in the laundry since March 1966. The recommended quantity was one ounce of powder per laundering cycle, but it was ascertained that the laundry was actually using 3 to 4 ounces.

Thin-layer chromatography of the serum and urine of the new case revealed an abnormal substance with characteristics that were identical to those detected in the previous infants' sera. Further studies in two different laboratories with improved methods of analysis have shown that the chemical in the urine and serum of the new case

was pentachlorophenol, and was clearly not one of the phenolic ingredients in the previously suspected disinfectant. Additionally, pentachlorophenol was identified in freshly laundered diapers obtained from the nursery. The quantity of pentachlorophenol varied from 1.5 to 5.7 mg. per diaper. Pentachlorophenol, when fed to rats, was found to be highly toxic and was isolated from urine of surviving rats in concentrations comparable to that found in the sick child. Unfortunately, no samples from the earlier cases remained for these more sophisticated analyses.

Actions have been instituted to prevent further illnesses that might be caused by the misuse of this product, or two other sodium pentachlorophenate-containing products that are recommended for similar purposes. The manufacturer has been directed to trace all sales and shipments of these products during the past 18 months, and to remove such products from all hospitals and any establishment that is involved in general laundry work. The company has voluntarily ceased sale of these three products.

(Reported by J. Earl Smith, M.D., Health Commissioner, Division of Health, Department of Health and Hospitals, City of St. Louis, Missouri; L. E. Loveless, Ph.D., Chemist, Clinical Laboratories, St. Louis, Missouri; E. A. Belden, M.D., Consultant, Communicable Disease Control, Local Health Services Section, Division of Health, Missouri Department of Public Health and Welfare; the Epidemiology and Pesticides Programs of the National Communicable Disease Center, Atlanta, Georgia; the Toxicology Section, Occupational Health Program, National Center for Urban and Industrial Health, Cincinnati, Ohio; and a team of EIS Officers.)

Editorial Note:

The clinical, laboratory, epidemiological, and pathological findings, as well as the prompt response to exchange transfusion, all indicate a toxic, rather than an infectious, cause of this outbreak. The fever, sweating, and acidosis are consistent with intoxication with certain phenolic derivatives, which are known to increase the metabolic rate¹. The symptoms described here are remarkably similar to industrial accidental poisonings resulting from overexposure to pentachlorophenol or its sodium salts^{2,3}. The exact manner in which the infants became poisoned cannot be established, but the most reasonable explanation is absorption through the intact skin as a result of repeated contact with diapers, blankets, and linens containing small, but readily absorbable, quantities of sodium pentachlorophenate. The antimildew agent, which is labelled not for use in laundering diapers or hospital linens, nevertheless, was in use in this hospital. Pediatricians, hospital administrators, housekeepers, and local health authorities should check commercial diaper services and hospital laundries to ensure that this product is not in use.

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AN OUTBREAK OF GASTROENTERITIS AND TYPHOID FEVER in United States Visitors to British Columbia

On September 29, 1967, two physicians from Portland, Oregon, reported three possible cases of typhoid fever to the City and State Health Departments. An immediate investigation revealed that during the third week of August, a group of 26 youths from the Portland area had travelled to Cranbrook, British Columbia, to attend an ice hockey training session. Twenty-five of these boys developed gastroenteritis. In addition, 41 persons from 11 families went to Cranbrook with their boys or to bring them home. Although the families stayed at different places in the area, 36 of the 41 family members developed cases of febrile gastroenteritis. All persons who became ill after arriving in British Columbia developed their illnesses between 2 and 11 days after arrival; mean and median onset dates were 7 days after arrival (Figure 2).

Among a total of 67 persons from Oregon who went to British Columbia, 61 had gastrointestinal symptoms. Of these, 80 percent had diarrhea, 64 percent had abdominal cramps, 54 percent reported fever, 47 percent were nauseated, 30 percent vomited, 33 percent experienced headache, 25 percent had chills, and 8 percent had bloody diarrhea. The shortest duration of illness was one hour, but several children have had intermittent symptoms for weeks; the median duration was 4 days. Only one case of a mild gastrointestinal illness occurred in a household contact who did not visit British Columbia. Otherwise, there were no secondary cases. Five children were hospitalized with gastroenteritis; the illnesses of three of these children were confirmed as typhoid fever.

Case No. 1

This 12-year-old boy arrived in British Columbia on August 20, 1967. On August 22, he developed fever, headache, intermittent diarrhea, nausea, and vomiting. He

returned to Portland on August 28 and was said to have headache, fever, and malaise. He was seen on several occasions as an outpatient at which times he denied diarrhea, no fever was observed, and there were no abnormal physical findings or weight loss. Finally, because of the concern of his grandmother over his sporadic symptoms, he was hospitalized for observation on September 7. The first fever spike was observed on September 10. Agglutinin titers for *Salmonella* were negative on September 7; on September 17, titers of 1:20 for group D "O" antigen and 1:80 for group D "H" antigen were observed. On September 15 *Salmonella typhi* was found on blood culture. Ampicillin was then given for 3 days with continuing diurnal temperature spikes as high as 105°F. Chloromycetin 250 mg every 6 hours was substituted, and the patient became afebrile within 36 hours.

Case No. 2

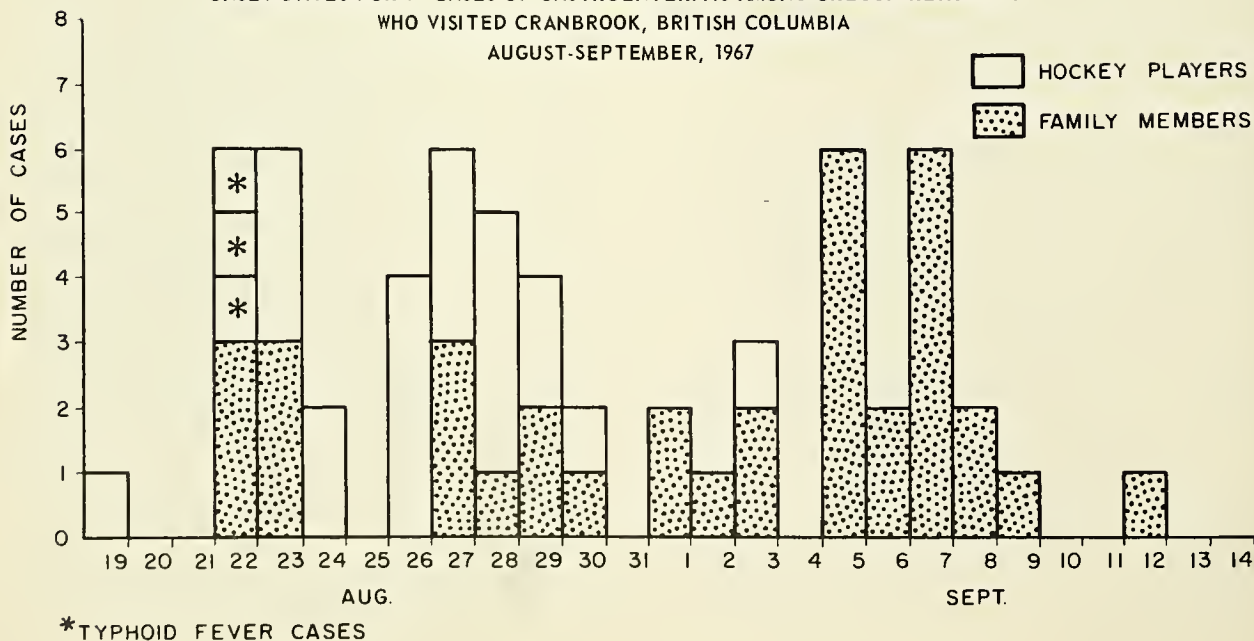
This 16-year-old boy arrived in British Columbia on August 19, 1967. On August 22, he experienced nausea, vomiting, and severe watery diarrhea for approximately one week. September 5 he developed pharyngitis, fever, photophobia, and headache. On September 8, he was admitted to a Portland hospital with a pulse rate of 104 and a temperature of 105.8°F. On physical examination the abdomen was diffusely tender with tenderness to percussion over the liver. On September 15, rose spots were observed. The "O" agglutinin titer rose from 1:80 on September 9 to 1:640 on September 18. During this period, the "H" titer rose from 1:20 to 1:640. The patient had no history of typhoid immunization. The erythrocyte sedimentation rate rose to 46 on September 15. On September 19, a blood culture yielded *S. typhi*. There was good clinical response from ampicillin and IV fluids.

Case No. 3

This 14-year-old brother of Case No. 2 also arrived in British Columbia on August 19 and developed nausea, vomiting, diarrhea, fever, and headache on August 22. Medication was given in Canada, and he became afebrile after 5 days; diarrhea, malaise, and anorexia persisted. A fever developed on September 12, and he was hospitalized with a temperature of 103.4°F. There was diffuse

Figure 2

ONSET DATES FOR 61 CASES OF GASTROENTERITIS AMONG OREGON RESIDENTS
WHO VISITED CRANBROOK, BRITISH COLUMBIA
AUGUST-SEPTEMBER, 1967



abdominal tenderness, particularly in the right upper quadrant. On September 16, the "O" agglutinin titer was 1:1280 and "IP" was 1:80 with no history of typhoid immunization. On September 19, *S. typhi* was recovered on blood culture. He responded well on ampicillin and fluids.

These three boys with typhoid fever were the only ones from the group of 26 who stayed at a vacation resort 12 miles south of Cranbrook, British Columbia, at Moyie Lake. This resort consists of several cottages, camping and trailer accommodations, and a restaurant. As a result of the Oregon outbreak, Canadian officials initiated an investigation in an effort to locate any additional typhoid cases and to determine the source of the outbreak at the resort. Four laboratory confirmed cases and two suspect cases of typhoid fever in Canadians were uncovered, all of whom were reported to have visited this resort during the 2-week period when the Oregon families were staying there. One of these cases is the cleaning lady for the resort. Further investigation revealed that there was a major plumbing repair at this resort on August 7, 1967. In 1966, two cases of typhoid fever were diagnosed in persons living within a 15-mile radius of the area.

Seven boys from Spokane, Washington, also attended the session; four of the boys developed gastroenteritis,

but none developed typhoid fever. In addition to the Canadian cases of typhoid fever which were subsequently discovered, a similar gastrointestinal illness was occurring among the Cranbrook community when the boys arrived in the area.

Stool specimens were obtained for culture from all Oregonians who visited British Columbia or have subsequently became ill. Except for the three confirmed cases of typhoid fever in Oregonians, all other visitors were found negative for enteric bacterial pathogens. Five stool specimens were examined for ova and parasites and were negative. Viral studies to date have been negative.

(Reported by Edward Goldblatt, M.D., State Health Officer, Monroe A. Holmes, D.V.M., State Public Health Veterinarian, and Mrs. Vivien Runte, Public Health Nurse, all with the Oregon State Board of Health; Thomas L. Meador, City Health Officer, Portland, Oregon; John A. Beare, M.D., Chief, Section of Epidemiology, Washington State Department of Health; R. W. Robertson, Chief, Quarantine Division, and John W. Davies, M.D., Chief, Epidemiology Division, both with the Department of National Health and Welfare, Ottawa, Canada; and an EIS Officer.)

STAPHYLOCOCCAL FOOD POISONING—New Jersey

On Wednesday, July 19, 1967, approximately 60 students and employees suddenly developed symptoms of gastroenteritis at a New Jersey State School for Girls. The illnesses occurred during the afternoon and early evening with the greatest number of persons reporting to the infirmary between 4:00 and 6:00 p.m. The symptoms were primarily nausea, cramps, frequent vomiting, and severe prostration, which were usually followed by diarrhea. The incubation periods were 1 to 9 hours with a mean of $4\frac{1}{2}$ hours. Most of the illnesses lasted 12 hours or less and the symptoms abated in nearly all patients by the following day. Hours of onset are shown in Figure 2.

Attack rates were calculated for all foods served by the school during the 48-hour period prior to the outbreak (Table 1). The attack rates on the foods served at lunch on Wednesday were significant for chicken salad and potato salad. Only one person of the 47 who became ill reported not to have eaten either item. The attack rates for the other meals were not unusual.

All 194 students and 45 of the 176 employees ate the lunch served at the cafeteria on Wednesday. One hundred persons (90 students and 10 employees) who ate this meal were interviewed. Forty-seven persons, including 3 employees, reported that they became ill on Wednesday. An

TABLE 1
ATTACK RATES FOR FOODS SERVED AT THE NOON MEAL
NEW JERSEY—JULY 19, 1967

Food Item	Ate the Food				Did Not Eat Food			
	Ill	Not Ill	Total	Attack Rate Percent	Ill	Not Ill	Total	Attack Rate Percent
Chicken Salad	44	34	78	56	3	10	13	23
Potato Salad	43	27	70	61	4	17	21	19
Lettuce & Tomato	39	30	69	57	8	14	22	36
Hard Boiled Egg	36	29	65	55	11	15	26	42
Olives	26	25	51	51	21	19	40	52
Pickles	33	32	65	51	14	12	26	54
Bread	31	25	56	55	16	19	35	46
Butter	26	25	51	51	21	19	40	52
Lemonade	35	35	70	50	12	9	21	57
Tea	1	4	5	20	46	40	86	54
Ice Cream	40	38	78	51	7	6	13	54
Water	42	39	81	52	5	5	10	50
Chicken Salad and/or Potato Salad	46	36	82	56	1	8	9	11

* The ill group includes only those persons who became ill on Wednesday.

additional five students reported comparable illnesses with onsets on Thursday morning, 13 to 22 hours after the Wednesday lunch. Another student and two employees reported illnesses at other times during the week which did not appear to be related to the outbreak. On the basis of institutional records, an estimated total of 60 to 65 persons probably became ill due to this episode of food poisoning.

Several types of specimens were collected. Vomitus or stool specimens were submitted by six ill persons. Samples of chicken salad and potato salad and home-made mayonnaise which was used in the preparation of the salads were obtained. Nasal swabs and material from any body lesions were also obtained for culture from 46 food handlers. Coagulase positive staphylococci were isolated from three vomitus specimens, one stool specimen, the chicken salad and potato salad, and from the nasal swabs of 13 food handlers. All were phage typed at the National Communicable Disease Center. The same phage type, 29/6/47/53/54/75/83A/+, was found in the three vomitus cultures, the stool culture, both foods and the nasal swab for the food handler who prepared the salads. No results are available on the tests for enterotoxin in the food items.

The salads were prepared Wednesday morning and refrigerated for several hours until served. Working temperatures in the kitchen were over 80°F. Each salad was divided and stored in two containers which were more than 10 inches deep.

Although the laboratory findings are not conclusive evidence, they support the epidemiologic premise that the infective organism was introduced into the salads during their preparation. The warm, freshly prepared salads were then placed into containers which were too deep to permit cooling at the center during the 2- to 3-hour refrigeration period. The random distribution of the cases in regard to serving time suggests that more than one container of salad had a substantial inoculum of the infective organism. Ideal temperature and moisture conditions at

Figure 1
OUTBREAK OF STAPHYLOCOCCAL FOOD POISONING
NEW JERSEY - JULY 19, 1967



the center of the containers would permit the production of enough toxin to cause the outbreak. Suitable recommendations were made regarding personal hygiene practices and methods of handling and storing perishable foods. (Reported by William J. Dougherty, M.D., Director, and Howard Rosenfeld, V.M.D., Division of Preventable Diseases, New Jersey State Department of Health.)

EASTERN ENCEPHALITIS - New Jersey

One human and 27 equine cases of Eastern Equine encephalitis (EEE) have been reported from New Jersey. Initially, two confirmed fatal cases of EEE in horses with onsets on August 8 and August 16, respectively, occurred in Cape May County in southern New Jersey at locations separated by a distance of approximately 10 miles.

A 67-year-old white retired male from Woodbine, Cape May County, whose residence was located 3 and 7 miles, respectively, from the two initial equine cases, developed fever and lethargy on August 16 which progressed to coma in the next 2 days. Spinal fluid showed pleocytosis and elevated protein. Blood specimens collected on the 4th and 16th day after onset revealed a rise in EEE hemagglutination inhibition titers from 1:160 to 1:5120. EEE log neutralization indices of bloods collected on the 4th and 6th days of illness were 2.4 and 2.2. The patient expired 20 days after onset. Subsequently, serologic and virologic

results have provided confirmation for nine additional equine cases; 16 other equine cases are classified as clinical suspects. The confirmed equine cases have been distributed in Cape May, Cumberland, Gloucester, Atlantic, and Burlington Counties.

New Jersey experienced heavy rainfall throughout the past summer, and surveillance revealed unusually high mosquito populations. *Aedes sollicitans* mosquitoes collected within a mile of the residence of the confirmed human case have thus far yielded at least two isolations of EEE virus.

(Reported by W. J. Dougherty, M.D., State Epidemiologist, Martin Goldfield, M.D., Director, Division of Laboratories, and Oscar Sussman, D.V.M., Coordinator, Veterinary Public Health Program, all with the New Jersey State Department of Health.)

SUMMARY OF REPORTED CASES OF INFECTIOUS SYPHILIS

CASES OF PRIMARY AND SECONDARY SYPHILIS: By Reporting Areas August 1967 and August 1966 - Provisional Data

Reporting Area	August		Cumulative January - August		Reporting Area	August		Cumulative January - August	
	1967	1966	1967	1966		1967	1966	1967	1966
NEW ENGLAND.....	36	49	239	321	EAST SOUTH CENTRAL.....	158	232	1,205	1,561
Maine.....	-	-	2	5	Kentucky.....	23	18	110	94
New Hampshire.....	2	-	7	7	Tennessee.....	19	34	185	210
Vermont.....	-	1	2	2	Alabama.....	81	137	642	876
Massachusetts.....	21	36	141	224	Mississippi.....	35	43	268	381
Rhode Island.....	1	2	23	20	WEST SOUTH CENTRAL.....	238	263	2,088	1,769
Connecticut.....	12	10	64	63	Arkansas.....	8	12	92	97
MIDDLE ATLANTIC.....	399	366	2,393	2,714	Louisiana.....	48	70	404	431
Upstate New York.....	33	38	195	250	Oklahoma.....	7	10	82	94
New York City.....	259	210	1,436	1,674	Texas.....	175	171	1,510	1,147
Pa. (Excl. Phila.).....	16	27	153	134	MOUNTAIN.....	51	49	406	284
Philadelphia.....	33	25	215	176	Montana.....	-	1	4	24
New Jersey.....	58	66	394	480	Idaho.....	-	2	16	3
EAST NORTH CENTRAL.....	272	302	2,100	2,115	Wyoming.....	-	-	12	-
Ohio.....	42	64	413	409	Colorado.....	6	4	49	33
Indiana.....	8	13	94	67	New Mexico.....	29	12	125	65
Downstate Illinois.....	10	16	106	125	Arizona.....	12	28	182	138
Chicago.....	105	97	634	685	Utah.....	1	-	6	5
Michigan.....	105	107	835	757	Nevada.....	3	2	12	16
Wisconsin.....	2	5	18	72	PACIFIC.....	147	142	1,218	1,186
WEST NORTH CENTRAL.....	43	38	217	284	Washington.....	3	3	35	26
Minnesota.....	9	3	35	22	Oregon.....	2	4	35	36
Iowa.....	7	9	27	47	California.....	139	134	1,139	1,101
Missouri.....	7	8	63	108	Alaska.....	-	1	2	6
North Dakota.....	2	-	4	5	Hawaii.....	3	-	7	17
South Dakota.....	4	1	24	25	U. S. TOTAL.....	1,950	1,956	14,128	14,410
Nebraska.....	11	8	29	30	TERRITORIES.....	86	94	613	654
Kansas.....	3	9	35	47	Puerto Rico.....	86	92	584	636
SOUTH ATLANTIC.....	606	515	4,262	4,176	Virgin Islands.....	-	2	29	18
Delaware.....	15	9	46	34					
Maryland.....	64	52	429	374					
District of Columbia.....	82	48	525	312					
Virginia.....	45	36	218	217					
West Virginia.....	3	7	14	49					
North Carolina.....	82	62	518	604					
South Carolina.....	65	78	566	616					
Georgia.....	114	77	666	690					
Florida.....	136	146	1,280	1,280					

Note: Cumulative Totals include revised and delayed reports through previous months.

CASES OF PRIMARY AND SECONDARY SYPHILIS: By Reporting Areas September 1967 and September 1966 - Provisional data

Reporting Area	September		Cumulative Jan - Sept		Reporting Area	September		Cumulative Jan - Sept	
	1967	1966	1967	1966		1967	1966	1967	1966
NEW ENGLAND.....	27	32	266	353	EAST SOUTH CENTRAL.....	144	194	1,349	1,755
Maine.....	-	-	2	5	Kentucky.....	15	10	125	104
New Hampshire.....	-	1	7	8	Tennessee.....	36	19	221	221
Vermont.....	1	-	3	2	Alabama.....	66	110	708	986
Massachusetts.....	11	21	152	245	Mississippi.....	27	55	295	436
Rhode Island.....	3	1	26	21	WEST SOUTH CENTRAL.....	254	272	2,342	2,041
Connecticut.....	12	9	76	72	Arkansas.....	13	19	105	116
MIDDLE ATLANTIC.....	322	322	2,715	3,036	Louisiana.....	67	51	471	482
Upstate New York.....	31	41	226	291	Oklahoma.....	6	11	88	105
New York City.....	194	189	1,630	1,863	Texas.....	168	191	1,678	1,338
Pa. (Excl. Phila.).....	23	10	176	144	MOUNTAIN.....	34	35	440	319
Philadelphia.....	26	26	241	202	Montana.....	-	2	4	26
New Jersey.....	48	56	442	536	Idaho.....	-	2	16	5
EAST NORTH CENTRAL.....	279	293	2,379	2,408	Wyoming.....	-	-	12	-
Ohio.....	56	67	469	476	Colorado.....	3	2	52	35
Indiana.....	15	7	109	74	New Mexico.....	11	8	136	73
Downstate Illinois.....	12	18	118	143	Arizona.....	16	16	198	154
Chicago.....	93	96	727	781	Utah.....	1	3	7	8
Michigan.....	92	98	927	855	Nevada.....	3	2	15	18
Wisconsin.....	11	7	29	79	PACIFIC.....	133	130	1,351	1,316
WEST NORTH CENTRAL.....	32	30	249	314	Washington.....	4	6	39	32
Minnesota.....	2	2	37	24	Oregon.....	5	2	40	38
Iowa.....	4	8	31	55	California.....	124	118	1,263	1,219
Missouri.....	15	6	78	114	Alaska.....	-	2	2	8
North Dakota.....	-	-	4	5	Hawaii.....	-	2	7	19
South Dakota.....	3	2	27	27	U. S. TOTAL.....	1,786	1,844	15,914	16,254
Nebraska.....	2	9	31	39	TERRITORIES.....	74	96	687	750
Kansas.....	6	3	41	50	Puerto Rico.....	70	92	654	728
SOUTH ATLANTIC.....	561	536	4,823	4,712	Virgin Islands.....	4	4	33	22
Delaware.....	4	6	50	40					
Maryland.....	56	42	485	416					
District of Columbia.....	100	51	625	363					
Virginia.....	16	24	234	241					
West Virginia.....	2	5	16	54					
North Carolina.....	76	78	594	682					
South Carolina.....	61	65	627	681					
Georgia.....	82	91	748	781					
Florida.....	164	174	1,444	1,454					

Note: Cumulative Totals include revised and delayed reports through previous months.

Morbidity and Mortality Weekly Report

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES

FOR WEEKS ENDED

OCTOBER 7, 1967 AND OCTOBER 8, 1966 (40th WEEK)

AREA	ASEPTIC MENINGITIS		BRUCELLOSIS	DIPHTHERIA	ENCEPHALITIS			HEPATITIS			
					Primary including unsp. cases		Post- Infectious	Serum		Infectious	
	1967	1966			1967	1966		1967	1966	1967	1966
UNITED STATES...	85	92	3	14	32	65	4	45	30	823	593
NEW ENGLAND.....	2	5	-	-	-	1	-	-	-	44	22
Maine.....	-	2	-	-	-	-	-	-	-	7	7
New Hampshire.....	-	-	-	-	-	-	-	-	-	-	1
Vermont.....	-	-	-	-	-	-	-	-	-	1	-
Massachusetts.....	1	-	-	-	-	-	-	-	-	20	6
Rhode Island.....	-	3	-	-	-	1	-	-	-	8	3
Connecticut.....	1	-	-	-	-	-	-	-	-	8	5
MIDDLE ATLANTIC.....	3	17	-	-	1	8	-	25	14	128	95
New York City.....	1	3	-	-	-	5	-	17	10	40	27
New York, Up-State.....	-	3	-	-	-	-	-	2	-	33	14
New Jersey.....	-	10	-	-	-	-	-	5	4	27	26
Pennsylvania.....	2	1	-	-	1	3	-	1	-	28	28
EAST NORTH CENTRAL...	4	6	-	-	12	11	-	1	-	110	113
Ohio.....	1	1	-	-	9	11	-	-	-	23	23
Indiana.....	-	1	-	-	-	-	-	-	-	21	14
Illinois.....	2	-	-	-	-	-	-	1	-	25	33
Michigan.....	1	3	-	-	3	-	-	-	-	36	42
Wisconsin.....	-	1	-	-	-	-	-	-	-	5	1
WEST NORTH CENTRAL...	7	3	2	-	5	18	1	-	-	58	32
Minnesota.....	2	2	1	-	1	2	1	-	-	8	7
Iowa.....	-	1	1	-	2	-	-	-	-	6	9
Missouri.....	-	-	-	-	-	-	-	-	-	42	10
North Dakota.....	-	-	-	-	-	-	-	-	-	-	-
South Dakota.....	-	-	-	-	-	-	-	-	-	-	-
Nebraska.....	-	-	-	-	-	-	-	-	-	2	3
Kansas.....	5	-	-	-	2	16	-	-	-	-	3
SOUTH ATLANTIC.....	24	8	1	-	3	4	1	-	3	98	57
Delaware.....	1	-	-	-	-	-	-	-	-	12	2
Maryland.....	18	-	-	-	-	-	-	-	1	12	10
Dist. of Columbia..	1	-	-	-	-	-	-	-	-	1	1
Virginia.....	-	-	-	-	3	1	1	-	-	5	9
West Virginia.....	1	-	-	-	-	-	-	-	-	4	6
North Carolina.....	-	3	-	-	-	-	-	-	1	8	8
South Carolina.....	1	-	-	-	-	-	-	-	-	7	3
Georgia.....	-	-	-	-	-	-	-	-	-	16	3
Florida.....	2	5	1	-	-	3	-	-	1	33	15
EAST SOUTH CENTRAL...	1	2	-	5	-	2	-	-	3	61	31
Kentucky.....	-	-	-	-	-	-	-	-	-	12	14
Tennessee.....	1	1	-	-	-	1	-	-	1	18	8
Alabama.....	-	-	-	5	-	-	-	-	2	11	6
Mississippi.....	-	1	-	-	-	1	-	-	-	20	3
WEST SOUTH CENTRAL...	5	13	-	9	3	13	-	1	-	90	53
Arkansas.....	-	-	-	-	-	1	-	-	-	6	3
Louisiana.....	3	4	-	9	3	7	-	1	-	14	5
Oklahoma.....	2	-	-	-	-	-	-	-	-	11	2
Texas.....	-	9	-	-	-	5	-	-	-	59	43
MOUNTAIN.....	2	1	-	-	2	5	-	-	-	30	40
Montana.....	-	-	-	-	-	-	-	-	-	11	4
Idaho.....	-	-	-	-	-	-	-	-	-	-	3
Wyoming.....	-	-	-	-	-	-	-	-	-	-	2
Colorado.....	2	-	-	-	2	4	-	-	-	-	2
New Mexico.....	-	-	-	-	-	-	-	-	-	11	12
Arizona.....	-	-	-	-	-	1	-	-	-	6	13
Utah.....	-	1	-	-	-	-	-	-	-	2	1
Nevada.....	-	-	-	-	-	-	-	-	-	-	3
PACIFIC.....	37	37	-	-	6	3	2	18	10	204	150
Washington.....	4	1	-	-	1	-	1	-	-	16	5
Oregon.....	6	-	-	-	-	1	-	4	-	5	28
California.....	25	35	-	-	5	2	1	14	10	182	114
Alaska.....	-	-	-	-	-	-	-	-	-	1	1
Hawaii.....	2	1	-	-	-	-	-	-	-	-	2
Puerto Rico	1	-	-	-	-	-	-	-	-	11	16

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES

FOR WEEKS ENDED

OCTOBER 7, 1967 AND OCTOBER 8, 1966 (40th WEEK) - CONTINUED

AREA	MALARIA	MEASLES (Rubeola)		MENINGOCOCCAL INFECTIONS, TOTAL			POLIOMYELITIS			RUBELLA	
	1967	1967	Cumulative		1967	Cumulative		Total	Paralytic		1967
			1967	1966		1967	1966	1967	1967	Cum. 1967	
UNITED STATES...	41	223	58,445	190,817	27	1,772	2,818	-	-	21	193
NEW ENGLAND.....	-	7	865	2,290	1	71	124	-	-	-	30
Maine.....	-	-	239	215	-	3	10	-	-	-	10
New Hampshire.....	-	-	74	80	-	2	9	-	-	-	-
Vermont.....	-	-	42	239	-	1	4	-	-	-	3
Massachusetts.....	-	6	357	787	-	33	50	-	-	-	5
Rhode Island.....	-	-	62	72	-	4	14	-	-	-	2
Connecticut.....	-	1	91	897	1	28	37	-	-	-	10
MIDDLE ATLANTIC.....	5	13	2,302	18,064	3	288	343	-	-	5	25
New York City.....	-	4	472	8,295	-	51	48	-	-	1	13
New York, Up-State.....	-	4	594	2,538	1	70	96	-	-	1	9
New Jersey.....	4	-	490	1,855	-	94	102	-	-	-	3
Pennsylvania.....	1	5	746	5,376	2	73	97	-	-	3	-
EAST NORTH CENTRAL...	1	34	5,575	68,944	2	251	443	-	-	3	51
Ohio.....	-	2	1,152	6,360	1	81	119	-	-	-	9
Indiana.....	1	5	602	5,716	-	40	79	-	-	-	-
Illinois.....	-	1	998	11,376	1	56	83	-	-	-	11
Michigan.....	-	3	943	14,557	-	57	119	-	-	3	8
Wisconsin.....	-	23	1,880	30,935	-	17	43	-	-	-	23
WEST NORTH CENTRAL...	-	8	2,873	8,724	3	78	150	-	-	3	12
Minnesota.....	-	-	123	1,643	-	19	34	-	-	-	-
Iowa.....	-	1	750	5,316	1	16	22	-	-	1	12
Missouri.....	-	4	337	532	1	16	57	-	-	-	-
North Dakota.....	-	2	872	1,116	1	2	11	-	-	-	-
South Dakota.....	-	-	55	40	-	6	5	-	-	-	-
Nebraska.....	-	1	642	77	-	13	8	-	-	-	-
Kansas.....	-	-	94	NN	-	6	13	-	-	2	-
SOUTH ATLANTIC.....	16	21	6,936	15,366	9	343	480	-	-	2	8
Delaware.....	-	1	49	257	1	7	4	-	-	-	1
Maryland.....	1	1	163	2,110	1	44	48	-	-	1	1
Dist. of Columbia..	-	1	24	383	-	10	12	-	-	-	-
Virginia.....	-	5	2,197	2,188	-	41	59	-	-	-	-
West Virginia.....	-	6	1,398	5,328	5	32	30	-	-	-	5
North Carolina.....	13	5	861	495	-	71	125	-	-	1	-
South Carolina.....	1	-	511	658	-	29	49	-	-	-	-
Georgia.....	-	-	36	234	1	51	63	-	-	-	-
Florida.....	1	2	1,697	3,713	1	58	90	-	-	-	1
EAST SOUTH CENTRAL...	-	9	5,230	19,784	5	139	247	-	-	1	6
Kentucky.....	-	3	1,340	4,732	3	40	87	-	-	-	1
Tennessee.....	-	6	1,893	12,333	2	59	84	-	-	-	4
Alabama.....	-	-	1,329	1,694	-	26	54	-	-	-	1
Mississippi.....	-	-	668	1,025	-	14	22	-	-	1	-
WEST SOUTH CENTRAL...	11	69	17,538	24,742	1	224	381	-	-	7	-
Arkansas.....	-	-	1,404	971	1	32	35	-	-	-	-
Louisiana.....	1	-	155	99	-	88	140	-	-	-	-
Oklahoma.....	10	-	3,351	492	-	17	19	-	-	1	-
Texas.....	-	69	12,628	23,180	-	87	187	-	-	6	-
MOUNTAIN.....	-	19	4,705	12,024	-	33	88	-	-	-	7
Montana.....	-	7	296	1,832	-	2	4	-	-	-	-
Idaho.....	-	3	389	1,587	-	3	5	-	-	-	-
Wyoming.....	-	-	181	166	-	1	6	-	-	-	-
Colorado.....	-	3	1,577	1,318	-	13	48	-	-	-	1
New Mexico.....	-	-	591	1,133	-	3	10	-	-	-	-
Arizona.....	-	-	1,020	5,302	-	4	10	-	-	-	5
Utah.....	-	6	382	641	-	4	-	-	-	-	1
Nevada.....	-	-	269	45	-	3	5	-	-	-	-
PACIFIC.....	8	43	12,421	20,879	3	345	562	-	-	-	54
Washington.....	4	22	5,478	3,711	-	31	40	-	-	-	20
Oregon.....	-	12	1,630	1,843	-	27	34	-	-	-	3
California.....	2	7	4,995	14,648	3	273	469	-	-	-	22
Alaska.....	-	1	145	535	-	10	15	-	-	-	1
Hawaii.....	2	1	173	142	-	4	4	-	-	-	8
Puerto Rico.....	-	4	2,133	2,854	-	13	13	-	-	-	-

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES
FOR WEEKS ENDED
OCTOBER 7, 1967 AND OCTOBER 8, 1966 (40th WEEK) - CONTINUED

AREA	STREPTOCOCCAL SORE THROAT & SCARLET FEVER	TETANUS		TULAREMIA		TYPHOID		TYPHUS FEVER TICK-BORNE (Rky. Mt. Spotted)		RABIES IN ANIMALS	
		1967	Cum. 1967	1967	Cum. 1967	1967	Cum. 1967	1967	Cum. 1967	1967	Cum. 1967
UNITED STATES...	5,978	4	174	2	140	8	324	3	281	59	3,402
NEW ENGLAND.....	858	-	2	-	1	2	7	-	1	2	91
Maine.....	15	-	-	-	-	-	-	-	-	2	19
New Hampshire.....	8	-	-	-	-	-	-	-	-	-	44
Vermont.....	48	-	-	-	-	-	-	-	-	-	22
Massachusetts.....	119	-	1	-	1	1	3	-	1	-	4
Rhode Island.....	59	-	-	-	-	-	1	-	-	-	2
Connecticut.....	609	-	1	-	-	1	3	-	-	-	-
MIDDLE ATLANTIC.....	191	-	12	-	-	2	33	1	35	6	80
New York City.....	10	-	6	-	-	1	17	-	-	-	-
New York, Up-State.	141	-	1	-	-	-	9	-	9	4	68
New Jersey.....	NN	-	1	-	-	-	3	-	15	-	-
Pennsylvania.....	40	-	4	-	-	1	4	1	11	2	12
EAST NORTH CENTRAL...	467	1	18	-	12	1	30	-	22	6	330
Ohio.....	21	-	4	-	-	-	7	-	11	5	115
Indiana.....	83	-	3	-	2	1	11	-	1	1	75
Illinois.....	71	1	9	-	10	-	3	-	10	-	63
Michigan.....	213	-	2	-	-	-	7	-	-	-	21
Wisconsin.....	79	-	-	-	-	-	2	-	-	-	56
WEST NORTH CENTRAL...	276	2	13	-	21	-	17	-	4	11	790
Minnesota.....	3	-	3	-	-	-	1	-	1	4	157
Iowa.....	135	-	1	-	1	-	3	-	-	1	106
Missouri.....	5	1	7	-	8	-	8	-	1	1	145
North Dakota.....	86	-	-	-	-	-	-	-	-	3	138
South Dakota.....	37	-	1	-	2	-	-	-	-	-	94
Nebraska.....	2	-	-	-	-	-	4	-	2	-	54
Kansas.....	8	1	1	-	10	-	1	-	-	2	96
SOUTH ATLANTIC.....	682	-	39	1	10	-	49	-	113	6	429
Delaware.....	4	-	-	-	-	-	-	-	-	-	-
Maryland.....	87	-	-	-	-	-	2	-	21	-	3
Dist. of Columbia..	13	-	-	-	-	-	2	-	-	-	5
Virginia.....	185	-	10	-	-	-	6	-	27	3	186
West Virginia.....	183	-	1	-	2	-	1	-	1	1	59
North Carolina.....	30	-	6	-	-	-	3	-	44	-	3
South Carolina.....	16	-	1	-	2	-	10	-	5	-	-
Georgia.....	28	-	3	1	5	-	14	-	15	2	105
Florida.....	136	-	18	-	1	-	11	-	-	-	68
EAST SOUTH CENTRAL...	872	-	30	-	9	-	54	-	49	7	645
Kentucky.....	19	-	3	-	1	-	23	-	14	2	151
Tennessee.....	685	-	8	-	6	-	9	-	23	5	445
Alabama.....	106	-	11	-	-	-	10	-	12	-	40
Mississippi.....	62	-	8	-	2	-	12	-	-	-	9
WEST SOUTH CENTRAL...	559	1	42	-	72	-	36	2	37	16	737
Arkansas.....	1	-	5	-	42	-	11	1	13	2	99
Louisiana.....	2	-	4	-	7	-	14	-	-	-	63
Oklahoma.....	58	1	3	-	18	-	7	-	15	8	266
Texas.....	498	-	30	-	5	-	4	1	9	6	309
MOUNTAIN.....	1,042	-	1	-	9	-	19	-	9	1	107
Montana.....	76	-	-	-	1	-	2	-	-	-	-
Idaho.....	73	-	-	-	-	-	-	-	-	-	-
Wyoming.....	45	-	-	-	2	-	-	-	-	-	5
Colorado.....	567	-	-	-	1	-	12	-	9	-	10
New Mexico.....	140	-	1	-	-	-	2	-	-	-	31
Arizona.....	73	-	-	-	-	-	3	-	-	1	49
Utah.....	68	-	-	-	5	-	-	-	-	-	3
Nevada.....	-	-	-	-	-	-	-	-	-	-	9
PACIFIC.....	1,031	-	17	1	6	3	79	-	11	4	193
Washington.....	333	-	-	-	2	-	1	-	2	-	1
Oregon.....	102	-	1	-	1	-	3	-	3	-	4
California.....	428	-	13	1	3	3	72	-	6	4	188
Alaska.....	64	-	-	-	-	-	-	-	-	-	-
Hawaii.....	104	-	3	-	-	-	3	-	-	-	-
Puerto Rico.....	13	-	16	-	-	1	6	-	-	1	30

Week No. 40

DEATHS IN 122 UNITED STATES CITIES FOR WEEK ENDED OCTOBER 7, 1967

(By place of occurrence and week of filing certificate. Excludes fetal deaths)

Area	All Causes		Pneumonia and Influenza All Ages	Under 1 year All Causes	Area	All Causes		Pneumonia and Influenza All Ages	Under 1 year All Causes
	All Ages	65 years and over				All Ages	65 years and over		
NEW ENGLAND:	659	411	20	33	SOUTH ATLANTIC:	1,079	565	33	67
Boston, Mass.-----	211	128	6	12	Atlanta, Ga.-----	135	62	3	6
Bridgeport, Conn.-----	49	31	3	3	Baltimore, Md.-----	288	133	5	8
Cambridge, Mass.-----	35	23	-	-	Charlotte, N. C.-----	44	14	2	7
Fall River, Mass.-----	19	10	-	2	Jacksonville, Fla.-----	54	28	2	6
Hartford, Conn.-----	56	31	1	5	Miami, Fla.-----	71	41	1	3
Lowell, Mass.-----	26	15	2	1	Norfolk, Va.-----	43	20	2	6
Lynn, Mass.-----	28	21	2	-	Richmond, Va.-----	104	61	1	6
New Bedford, Mass.-----	32	23	1	1	Savannah, Ga.-----	36	16	3	2
New Haven, Conn.-----	30	9	-	2	St. Petersburg, Fla.-----	65	58	7	-
Providence, R. I.-----	51	32	-	5	Tampa, Fla.-----	62	33	3	4
Somerville, Mass.-----	8	6	-	-	Washington, D. C.-----	193	75	3	17
Springfield, Mass.-----	38	32	2	-	Wilmington, Del.-----	44	24	1	2
Waterbury, Conn.-----	23	16	-	-					
Worcester, Mass.-----	53	34	3	2	EAST SOUTH CENTRAL:	630	334	22	40
MIDDLE ATLANTIC:	3,039	1,752	105	135	Birmingham, Ala.-----	103	59	3	11
Albany, N. Y.-----	49	28	1	3	Chattanooga, Tenn.-----	65	32	2	3
Allentown, Pa.-----	39	23	1	4	Knoxville, Tenn.-----	44	26	1	-
Buffalo, N. Y.-----	137	75	3	3	Louisville, Ky.-----	120	71	8	9
Camden, N. J.-----	44	26	8	3	Memphis, Tenn.-----	130	64	5	7
Elizabeth, N. J.-----	34	23	1	-	Mobile, Ala.-----	28	14	-	1
Erie, Pa.-----	44	23	2	2	Montgomery, Ala.-----	31	15	-	3
Jersey City, N. J.-----	72	50	4	2	Nashville, Tenn.-----	109	53	3	6
Newark, N. J.-----	86	39	5	18	WEST SOUTH CENTRAL:	1,135	635	28	72
New York City, N. Y.-----	1,581	905	44	59	Austin, Tex.-----	33	18	2	-
Paterson, N. J.-----	43	27	2	-	Baton Rouge, La.-----	45	24	1	2
Philadelphia, Pa.-----	344	193	10	11	Corpus Christi, Tex.-----	35	19	-	2
Pittsburgh, Pa.-----	185	103	2	10	Dallas, Tex.-----	165	84	-	13
Rochester, Pa.-----	46	31	2	-	El Paso, Tex.-----	27	11	1	3
Rochester, N. Y.-----	105	68	10	7	Fort Worth, Tex.-----	91	49	3	-
Schenectady, N. Y.-----	26	17	1	-	Houston, Tex.-----	214	107	9	13
Scranton, Pa.-----	42	26	3	1	Little Rock, Ark.-----	53	35	4	3
Syracuse, N. Y.-----	70	39	1	7	New Orleans, La.-----	163	94	3	12
Trenton, N. J.-----	30	14	1	3	Oklahoma City, Okla.-----	61	38	3	4
Utica, N. Y.-----	32	24	2	1	San Antonio, Tex.-----	119	70	1	7
Yonkers, N. Y.-----	30	18	2	1	Shreveport, La.-----	48	26	1	7
EAST NORTH CENTRAL:	2,530	1,423	89	139	Tulsa, Okla.-----	81	50	-	6
Akron, Ohio-----	68	40	-	5	MOUNTAIN:	395	235	18	35
Canton, Ohio-----	28	22	-	-	Albuquerque, N. Mex.-----	38	16	1	2
Chicago, Ill.-----	757	394	30	47	Colorado Springs, Colo.-----	27	15	4	2
Cincinnati, Ohio-----	146	86	1	11	Denver, Colo.-----	111	73	3	7
Cleveland, Ohio-----	197	97	4	8	Ogden, Utah-----	20	11	3	1
Columbus, Ohio-----	120	62	6	6	Phoenix, Ariz.-----	77	46	3	10
Dayton, Ohio-----	87	57	1	2	Pueblo, Colo.-----	21	13	1	2
Detroit, Mich.-----	321	184	4	14	Salt Lake City, Utah-----	49	31	1	8
Evansville, Ind.-----	41	29	2	2	Tucson, Ariz.-----	52	30	2	3
Flint, Mich.-----	33	17	1	4	PACIFIC:	1,471	894	40	59
Fort Wayne, Ind.-----	38	21	2	1	Berkeley, Calif.-----	24	21	-	2
Cary, Ind.-----	57	27	6	2	Fresno, Calif.-----	30	15	2	-
Crand Rapids, Mich.-----	73	54	12	4	Glendale, Calif.-----	38	29	-	1
Indianapolis, Ind.-----	165	96	7	10	Honolulu, Hawaii-----	44	25	1	1
Madison, Wis.-----	28	13	-	1	Long Beach, Calif.-----	73	53	2	2
Milwaukee, Wis.-----	116	72	6	6	Los Angeles, Calif.-----	437	267	8	16
Peoria, Ill.-----	35	22	1	4	Oakland, Calif.-----	88	47	2	2
Rockford, Ill.-----	34	22	3	2	Pasadena, Calif.-----	45	29	-	1
South Bend, Ind.-----	41	24	1	-	Portland, Oreg.-----	110	67	5	4
Toledo, Ohio-----	102	59	2	10	Sacramento, Calif.-----	59	33	4	5
Youngstown, Ohio-----	43	25	-	-	San Diego, Calif.-----	95	53	-	11
WEST NORTH CENTRAL:	797	480	27	40	San Francisco, Calif.-----	160	85	5	3
Des Moines, Iowa-----	59	35	3	3	San Jose, Calif.-----	43	25	3	6
Duluth, Minn.-----	11	6	-	-	Seattle, Wash.-----	129	80	5	5
Kansas City, Kans.-----	36	20	2	3	Spokane, Wash.-----	50	37	2	-
Kansas City, Mo.-----	131	76	4	5	Tacoma, Wash.-----	46	28	1	-
Lincoln, Nebr.-----	36	25	2	-	Total	11,735	6,719	382	620
Minneapolis, Minn.-----	106	63	1	7					
Omaha, Nebr.-----	64	33	1	6					
St. Louis, Mo.-----	223	150	8	9					
St. Paul, Minn.-----	76	49	1	7					
Wichita, Kans.-----	46	23	5	-					
Cumulative Totals including reported corrections for previous weeks									
All Causes, All Ages -----491,454									
All Causes, Age 65 and over-----280,285									
Pneumonia and Influenza, All Ages-----17,261									
All Causes, Under 1 Year of Age-----25,113									

*Estimate - based on average percent of divisional total.

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ERRATA

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In the table, "Deaths in 122 United States Cities for Week Ended September 30, 1967," data for the County of Los Angeles rather than for the City were inadvertently published. Incorrect figures should be changed as follows:

	All Causes		Pneumonia and Influenza All Ages	Under 1 Year All Causes
	All Ages	65 years and over		
Los Angeles	459	276	5	23
Pacific Division	1,439	883	26	61
122 Cities Total	11,815	6,665	391	632

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In the article "Obscure Disease Related to African Monkeys—Importation and Use in the United States," the last two sentences of the 1st paragraph read:

"At least 23 persons have been identified who assisted with the nephrectomy of these monkeys or in the mincing and trypsinization of their kidneys. Approximately 1,700 persons are known to have been exposed to operated monkeys or their kidney tissue; none of these persons has experienced an unusual febrile illness to date."

The latter sentence should read:

"Taking into consideration the number of exposures to individual open monkeys that each of these 23 persons had, there were approximately 1,700 person-to-open-monkey exposures; . . ."

THE MORBIDITY AND MORTALITY WEEKLY REPORT, WITH A CIRCULATION OF 17,000, IS PUBLISHED AT THE NATIONAL COMMUNICABLE DISEASE CENTER, ATLANTA, GEORGIA.

DIRECTOR, NATIONAL COMMUNICABLE DISEASE CENTER

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IN ADDITION TO THE ESTABLISHED PROCEDURES FOR REPORTING MORBIDITY AND MORTALITY, THE NATIONAL COMMUNICABLE DISEASE CENTER WELCOMES ACCOUNTS OF INTERESTING OUTBREAKS OR CASE INVESTIGATIONS WHICH ARE OF CURRENT INTEREST TO HEALTH OFFICIALS AND WHICH ARE DIRECTLY RELATED TO THE CONTROL OF COMMUNICABLE DISEASES. SUCH COMMUNICATIONS SHOULD BE ADDRESSED TO:

THE EDITOR
MORBIDITY AND MORTALITY WEEKLY REPORT
NATIONAL COMMUNICABLE DISEASE CENTER
ATLANTA, GEORGIA 30333

NOTE: THE DATA IN THIS REPORT ARE PROVISIONAL AND ARE BASED ON WEEKLY TELEGRAMS TO THE NCDC BY THE INDIVIDUAL STATE HEALTH DEPARTMENTS. THE REPORTING WEEK CONCLUDES ON SATURDAY; COMPILED DATA ON A NATIONAL BASIS ARE RELEASED ON THE SUCCEEDING FRIDAY.

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